Vancouver Division of Family Practice
A GPSC initiative

Vancouver Coastal Health
Promoting wellness. Ensuring care.

PATIENT REFERRAL TO VANCOUVER URGENT PRIMARY CARE CENTRE DURING THE COVID-19 PANDEMIC

This form is only for use by Vancouver FPs/NPs or FPs/NPs that have patients residing in Vancouver

* **These sites are NOT equipped with ventilators and are not suited to see patients with severe respiratory issues. These patients should be referred directly to the ER (please call ahead)**

REACH: For medical assessment (COVID/Respiratory/Other), please fax the referral and call REACH to discuss (604-216-3138). The patient will be contacted for an appointment. For COVID testing only, please tick the appropriate box below, send the referral along with the mandatory lab requisition attached to this form and the patient will be contacted to come in.

City Centre UPCC: Please fax the referral and direct the patient to the UPCC where they will be triaged for care. For COVID testing only, please tick the appropriate box below, send the referral along with the mandatory lab requisition attached to this form and direct the patient to the UPCC. If you wish to speak to a team member, please call (236-521-3558).

For COVID testing ONLY, patients can also be sent directly to the **St. Vincent's Testing Site** (33rd Ave, just west of Heather). This is a drive-thru site where patients are tested within their vehicle. Referral form not needed.

☐ **I confirm that I have already conducted a virtual (phone/video) visit with the patient before referring**

☐ **I want to continue to collaboratively care for this patient (please ensure your contact information is accurate)**

☐ **COVID testing only, I will follow up on the results** **(Virology requisition with accurate ordering physician and patient information required. See page two of this form. Click here for instructions on filling in the form)**

PATIENT INFORMATION	
Last name	
First name	
Date of birth (YYYY/MM/DD)	
PHN	
Primary contact number	
2019-nCoV status	◯ Unknown ◯ Positive ◯ Negative
(if available) Test Date	
Date of Referral (YYYY/MM/DD)	

REFERRING FP/NP	
Referring practitioner	
MSP #	
Clinic name	
Street address	
Fax	
Private Line	
Cell phone*	* critical for urgent collaborative mgmt & F/U plan
Primary care provider	

REASON FOR REFERRAL - (Check all that apply)

Testing/Assessment/Treatment	Urgent support to self isolate/socially distance (Currently only available at REACH)	Other:
☐ Needs COVID/respiratory assessment ☐ Non-COVID issue Details: _____	☐ Food insecurity ☐ Precarious/unsuitable housing ☐ Income insecurity ☐ Addiction - withdrawal management ☐ Other: _____	

PAST MEDICAL HISTORY /OR/ ☐ EMR summary sheet attached

Medications	Chronic conditions/comorbidities

Allergies	

Fax this form with any attachments to: **REACH - (604) 216.3139** **City Centre - (236) 521.3628**

Save Print

VDOFP - 04.23.2020 V3

VI

BC Centre for Disease Control
An agency of the Provincial Health Services Authority

Public Health Laboratory

655 West 12th Avenue, Vancouver, BC V5Z 4R4
www.bccdc.ca/publichealthlab

Virology Requisition

VI

LM LABS

Section 1 - Patient Information

PERSONAL HEALTH NUMBER (or out-of province Health Number and province)	**DOB** (DD/MMM/YYYY)	**GENDER** ☐ M ☐ F ☐ UNK
PATIENT SURNAME	**PATIENT FIRST AND MIDDLE NAME**	
ADDRESS	**CITY**	**POSTAL CODE**

DATE RECEIVED

LABORATORY USE ONLY

OUTBREAK ID

Section 2 - Healthcare Provider Information

ORDERING PHYSICIAN (Provide MSC#)
Name and address of report delivery

☐ **I do not require a copy of the report**

CLINIC OR HOSPITAL
Name and address of report delivery

PHSA CLIENT NO.

ADDITIONAL COPIES TO: (Address / MSC#)

1.

2.

3.

SAMPLE REF. NO.

DATE COLLECTED
(DD/MMM/YYYY)

TIME COLLECTED
(HH:MM)

Section 3 - Test(s) Requested

PATIENT STATUS

☐ Hospital inpatient ☐ ER patient

☐ History of contact with infection

Travel history _____

SIGNS / SYMPTOMS

Date of Onset: _____ (DD/MMM/YYYY)

☐ Asymptomatic ☐ Cough

☐ Fever ☐ Rash

☐ Upper Respiratory Infection ☐ Lower Respiratory Infection

☐ Other, specify: _____

RESPIRATORY VIRUSES

☐ Nasopharyngeal swab ☐ Nasal swab

☐ Bronchoalveolar lavage ☐ Nasal wash

☑ Other, specify: COVID-19

POC Tested by Submitter:

Influenza A	○ Positive	○ Negative
Influenza B	○ Positive	○ Negative
RSV	○ Positive	○ Negative

HERPES VIRUSES

☐ Genital lesion for HSV ☐ Non-genital lesion for HSV

☐ Skin swab for Varicella-Zoster

☐ Other, specify: _____

Urine for:

☐ Cytomegalovirus

GASTROINTESTINAL VIRUSES

Feces* for:

☐ GI Panel (Norovirus, Adenovirus, Astrovirus, Rotavirus, Sapovirus)

☐ Other, specify: _____

***Guideline for Ordering Stool Specimens**
www.bcguidelines.ca/gpac/guideline_diarrhea.html

HEPATITIS VIRUSES

EDTA Blood for:

☐ HCV RNA Quantitative (Use for diagnosis and monitoring)

☐ HCV Genotyping

For other available tests and additional information, consult the Public Health Laboratory's *eLab Handbook* at www.elabhandbook.info/PHSA/Default.aspx

ENCEPHALITIS / MENINGITIS

Cerebrospinal Fluid for:

☐ Encephalitis (e.g. HSV-1, West Nile Virus*)

For WNv, specify travel to endemic area if not WNv season: _____

*Offered during WNv season

☐ Meningitis (HSV-2, Enterovirus)

☐ Other, specify: _____

BIOPSY / AUTOPSY / OTHER TESTS

☐ Specify: _____

MEASLES / MUMPS / RUBELLA VIRUSES

☐ Measles ☐ Rubella*

☐ Urine

☐ Nasal / Nasopharyngeal swab

☐ Other, specify: _____

☐ Mumps

☐ Buccal swab

☐ Urine

*Sample forwarded to reference laboratory for testing

DATE INOC. **LABORATORY USE ONLY**

DATE	DAY	RMK	A549	MRC-5	

For information on sample collection, please call Virology Lab at (604) 707-2623